

State File No. _____

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Green
 (b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 1225 1/2 Pacific 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community _____
years, months or days 5 2 17

3. (a) PRINT FULL NAME Mary Elizabeth Candie
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced Child
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased April 28 1939
(Month) (Day) (Year)

8. AGE: Years ✓ Months 10 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace MO 0
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____
 MOTHER FATHER { 12. Name Jimmie Candie
 18. Birthplace Okl. Okla.
(City, town, or county) (State or foreign country)
 14. Maiden name Mary Jane Smith
 15. Birthplace Ark
(City, town, or county) (State or foreign country)

16. (a) Informant Jimmie Candie
 (b) Address 1225 1/2 E Pacific

17. (a) Burial (b) Date thereof 3/6/40
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Hazelwood Cem

18. (a) Signature of funeral director W. Campbell
 (b) Address 869 Wash Ave Springfield Mo

19. (a) 3/5/40 (b) Chas. A. Hedge
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Greene
 (c) City or town Springfield
(If outside city or town limits, write "RURAL")
 (d) Street No. 1225 1/2 E Pacific
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 4 1940
 year _____ hour 11 minute 41 M.

21. I hereby certify that I attended the deceased from Feb 28, 1940, to March 4, 1940
 that I last saw her alive on March 2, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia ✓ Duration 6 days.

Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? 200 (Specify type of place)
 (e) Means of injury _____

23. Signature [Signature] (M. D. or other) 1
 Address 1020 Sheridan Date signed 3-5-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

39
3
6

1072

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

X

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10945-

Registrar's No. 231

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 318

Primary Registration District No.

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Bremer
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME Mary Elizabeth Candie

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color col race _____ 6. (a) Single, widowed, married, divorced, child

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year _____

7. Birth date of deceased. (Month) _____ (Day) _____ (Year) _____

8. AGE: Years _____ Months 10 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH Month Mar day 4 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to Primary Cause

Due to 107W

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature G.C. Loney (M. D. or other) _____

Address Springfield _____ Date _____

SUPPLEMENTAL

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

1940

S-10945